NAVY MEDICINE

LEGACY

Spring 2021

THE NAVY MEDICAL RETIREE DIGEST

VISIT TO COMMUNITY VACCINATION CENTER, APRIL 2021

Surgeon General and FORCM Roberts visiting Navy-led vaccination team at York College, Queens, N.Y.

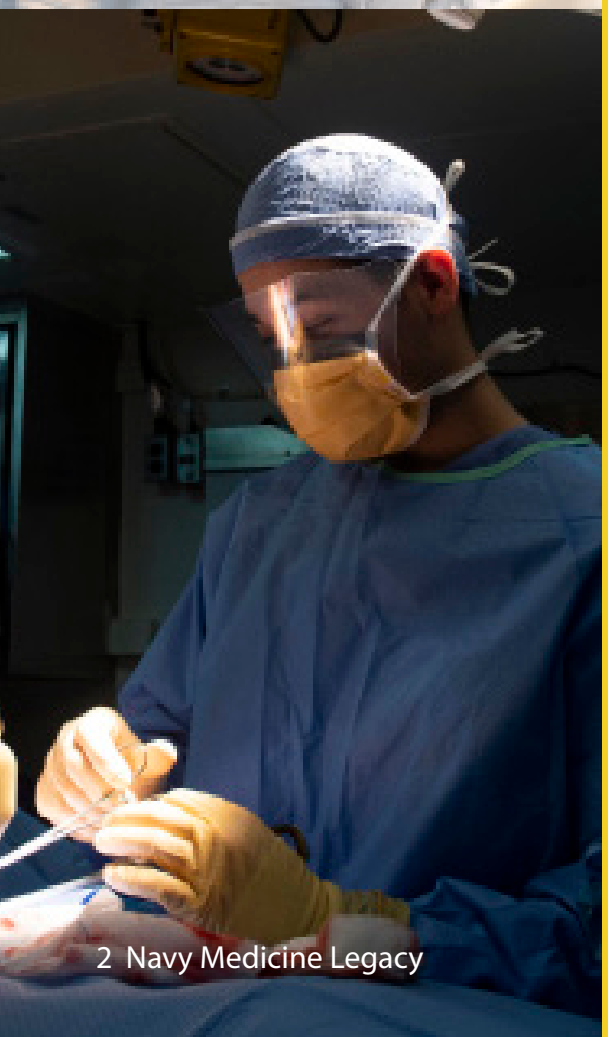
Photo by Cmdr. Denver Applehans

SURGEON GENERAL'S OPENING REMARKS

Surgeon General Leadership Symposium, 11 May 2021

The last year has been like no other in our lifetimes as we confronted a deadly adversary, the SARS-CoV-2 virus and the disease it causes, COVID-19. The battle continues today. Throughout this global pandemic, the operational tempo of Navy Medicine remains high, as we protect the readiness and health of our Sailors, Marines and their families, along with making direct contributions to the whole of Nation response to help our fellow citizens in need. I want to assure you that despite these unprecedented challenges, the One Navy Medicine team remains relevant, ready and responsive.

Foundational to Navy Medicine's mission effectiveness is being in sync with the strategic directions articulated by the Chief of Naval Operations and Commandant of the Marine Corps in their seminal documents CNO Navigation Plan 2021 and the Commandant's Planning Guidance 2019, respectively. In concert with leadership's guidance, I developed four lines of effort to help vector Navy Medicine support of these strategic imperatives. Our four priorities – People, Platforms, Performance and Power – ensure important readiness linkages to our Marines and Sailors: Well-trained People, working as cohesive teams on optimized Platforms, demonstrating high value Performance that will project medical Power in support of Naval Superiority. . .



NAVY MEDICAL LEGACY

A RETIREE DIGEST

INSIDE THIS ISSUE:

EDITOR'S NOTE:

Navy Medicine Legacy is digital publication for the Navy Medical retiree community. We would love to know what topics and themes you are interested in us covering in order to meet your information needs. We also welcome all story ideas, news items and articles for inclusion in future editions. To share feedback please contact our editorial team at: usn.ncr.bumedfchva.mbx.navy-medicine-retiree-news@mail.mil

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SURGEON GENERAL'S OPENING REMARKS (cont'd)

PEOPLE:

First and foremost, it starts with People because People are our foundation. Any good organization knows how valuable its people are. For us, it's extremely well-trained people who are ready and able to practice their skills in very austere environments, unique environments. And in fact, Navy Medicine is the only medical service that functions in all four environments – sea, air, land and space. That sets us apart and I think it's critically important that we understand that, and know that our folks have to be ready to operate in all of those environments.

As I drafted the 4P's I recognized that our landscape had changed dramatically, courtesy of Congress, courtesy of external actors around the world, i.e., the global peer competition that we're engaged in. And it required that we refocus as Navy Medicine. Being able to clearly delineate our direction through the 4P's was important to me, and I hope as leaders that you're sharing the importance of these as our construct, as our priorities going forward with your people, and that you spend time and go over this, and hopefully today's discussion will help you understand my perspective.

PLATFORMS:

Those extremely well-trained People practice on unique platforms. Of course, our marquee platform are the T-AHs, but in fact, as we're learning increasingly, the MTF is a platform, and so the training that we do--the reps and sets, the KSA generation--they're all occurring at that MTF, so while the DHA assumes authority, direction and control of the health care delivery mission, we have established the NMRTC as our platform within the MTF to ensure we are ready to go down range and do what only we can uniquely do as the medical support for the premier naval force in the world. That means developing our capabilities to provide world class care in distributed maritime, expeditionary advanced basing and contested littoral environments.

PERFORMANCE:

Performance is behavior. Performance is culture. And I have emphasized high-reliability, and I had the good fortune as a junior surgeon to work with Captain John Webster at Naval Medical Center San Diego as one of my mentors, one of my faculty members. He was the first one who introduced me to high-reliability concepts. He was a man way ahead of his time in understanding the importance of high-reliability behavior in the production of safe-patient care, and the elimination of preventable medical error. I became a disciple of his in terms of understanding these principles and using them in the operating room. I was then able to apply those principles in Iraq with a role two damage control surgery team that achieved high survival rates despite high volumes of severely injured war fighters. This experience really drove home the power of high-reliability. As I rose up within executive medicine, I saw that there was tremendous opportunity to apply those principles to our organization.

We have seen great examples over the last year of applied rapid-cycle feedback, of never being content, responding and demonstrating resilience. Frankly, we were back on our heels this time last year with the USS Theodore Roosevelt--25% of the crew infected with the coronavirus. And then fairly close on those heels, USS Kidd, and a remarkable response by staff members from NMRTC Jacksonville, led by Captain Case, to get a team in less than a day aboard her to help the terrific independent duty corpsman, who had recognized what was going on based on guidance provided by Navy Medicine, and was able to identify that he had an issue and needed help, and then we were able, again, to get testing equipment and a team to assist that independent duty corpsman and minimize the size and severity of the outbreak.

Lessons learned from Theodore Roosevelt and those from USS Kidd led to the generation of t standard operating guidance and the rapid refinement of that standard operating guidance working very closely with our fleet medical partners. And I'm proud to say that since that time, , while there have been outbreaks, no other naval vessel has been disabled because of the COVID virus. So I think we should recognize what a great demonstration of resilience that that is. And that's what a high-reliability organization is. It's not an organization that is perfect; it's one that minimizes the amplitude of unexpected change and continues to operate at a high level despite those challenges.

When you take all three of those things–extremely

well-trained and dedicated People operating on optimized Platforms, demonstrating high-reliability Performance, it gets us to our unique ability to project Medical Power in support of Naval Superiority. That is why we exist and what we uniquely do.

POWER:

Now, I'll confess, as an orthopedic surgeon, when I envisioned the 4P's and the projection of that Power, my thoughts were primarily combat casualty care based on personal experience and based on our history. Lo and behold, three months after taking over I began my Orthopedic Virology fellowship, and it's been quite an education. And what has been really reassuring and gratifying to me is that our experts in the fields appropriate to the response to a viral outbreak, a pandemic, have stepped to the fore and have demonstrated incredible professionalism and have really, I believe, helped us turn the tide. Hopefully you're getting the Navy Medical Intelligence Report--originally the Scientific Report--primarily, initially, focused on COVID, recognizing that the ability to rapidly go through best available evidence, synthesize that, and get it out to the people who need that information is a real success factor, and kudos to our team who have been doing that continuously since the pandemic began.

I will tell you that CNO reads it religiously. I get great feedback from the Undersecretary of the Navy, who appreciates the value of that information. But more importantly, that information is getting in the hands, through the Chief Medical Officer network and other venues that information is getting in the hands of those at ground zero that are taking care of our warfighters, past and present, and their families. And I think there's a wonderful precedent that's been set there, and I've asked the team to open the aperture, so you probably have seen over the last month that we've added non-COVID topics, and I see this as something that will continue into the future. And that same scientific panel has been available 24/7 to the Fleet and Marine Corps surgeons, and actually have a weekly scheduled event where questions can be answered and solutions formulated that can applied immediately.

Of course, I can't forget to mention all of our stellar medical teams that have deployed starting with the Mercy and Comfort and our ad hoc EMF medical teams, and then the 44 person Acute Care team and seven person Rural Rapid Response Teams developed after discussions with FEMA and finally our community vaccination teams that stood up in 11 cities nationwide to vaccinate our fellow American citizens. Over 6,000 Navy Medical personnel, including our outstanding selfless reservists, have deployed as part of the whole of government approach to the virus. I couldn't be prouder of their flexibility and can do spirit. Talk about medical power projection!

So that has been the way that Navy Medicine has primarily projected Power, in addition to our traditional means of projecting Power, and that's been, for this surgeon, that's just been eye-watering in terms of seeing those individuals who often, frankly, labor in the shadows to be able to step forward and demonstrate their expertise. Our Navy and Marine Corps Public Health Center has just been a powerhouse in terms of production of guidance that, frankly, has led, in many cases, DoD, and in some cases the nation, in terms of understanding how you operate in a COVID environment, and then in a vaccinated environment. Their most recent work has been modeling the vaccination threshold at which you can safely relax shipboard restrictions. Truly impressive, cutting edge work.

And that leads me to my last point, before I turn it over to Force Roberts, is to ask you to please, reengage your folks who have elected to not get vaccinated. From my perspective, the development of the SARS-CoV-2 vaccines is a triumph of medical and genomic technology. There is concern that they were developed quickly, but in fact, if you go back and read how they were developed, it's included over a decade of work in terms of structural vaccine development, but also the cherry on the top is the ability to use genomics to rapidly sequence the spike protein portion of the virus and attach that to that mRNA vehicle. So I would just ask your folks to recognize that although they may not see a personal benefit, their unit, their community and the nation will benefit if they get the vaccine. And for those who are more transactional, recognize that there are already efforts within DoD to start to identify vaccinated only gymnasiums, and to loosen restrictions for those that are vaccinated. So, even if it's only enlightened self-interest, please play that card because my goal is that we get over 90% of our own personnel vaccinated just like we do for the flu, and I'd love to do that before it's mandated. ●

SGLS: FORCE MASTER CHIEF'S OPENING REMARKS

SG, DSG, Admirals, Senior leaders, I tell you, what an honor to be here and I'm really privileged. Last year going into this year has been a year that I hope we never duplicate again. But I tell you, if we had to, we could certainly do it. We had unparalleled adaptability and response to an unpredictive adversary, which was COVID-19. No one could ever predict what we did. But I tell you, for an example, you look at dental all around our commands, they closed up shop, they closed up their routines, and they went straight to the dental clinic doing something they're not normally doing, which is taking care of handling the pandemic, whether it was testing or treating patients, it didn't matter. They were doing stuff that they normally wouldn't do. From the beginning this was One Team, One Fight.

I'd be remiss if I didn't mention the Fleet Marine Force, PACFLEET and Fleet Forces and all their teams, because the things that they did on the TR and the things that they were doing on the piers to ensure, as a group, as a team, as we all know we can't do without them, is remarkable, and I'd like to call them out too.

We've leveraged hundreds of years of skills to be part of the DSCA missions and it's something that we never thought we'd be doing in our lifetimes. 781 sailors--that's officers and enlisted--at 22 different sites from Tuba City, Arizona, to Queens, New York, we really supported our communities with something that we're not used to doing. We have some young sailors that want to be part of these missions.

As we move ahead I would ask that we keep our people informed of the decisions that are being made, bring them to the table and get them involved. Let them know where we're heading, whether it's manning reductions or BUMED going into the same direction as DHA--let the sailors know what's going on. Sit down in small groups. And this is not an easy discussion. I just came back from Pensacola and they're very, very invested in the loss of the 340 person or billets lost on them, so I can only imagine--and that's just one command--how many other commands have the same investment of what we're losing, what do we still have to continue to do, how are we going to be able to do this, active duty, beneficiaries--have that discussion because it concerns them, it concerns you and it concerns us. ●

FORCM Michael J. Roberts

SGLS: NAVY MEDICINE COVID-19 UPDATE

Deputy Surgeon General Remarks

RADM GAYLE SHAFFER

It's hard to believe that it's been more than a year since the COVID-19 pandemic was first reported, and since December of 2019, Navy Medicine has really been on the forefront, engaged in and supporting the U.S. Navy and Marine Corps, Department of Defense, government agencies and international efforts to help protect sailors, Marines, Department of Navy civilians and our fellow citizens from the coronavirus.

As Deputy Surgeon General it is truly humbling to be part of a team comprised of military and civilians who link arms every day to project medical power in support of Naval Superiority. Now, I've been known to say you can't make this stuff up, and no sooner than getting started on the execution of the Surgeon General's strategic plan, one week on the job as Deputy Surgeon General, BUMED found itself in full-time COVID operations. Pairing high-velocity learning and scientific discovery with a forward operationally focused research and development, Navy Medicine has provided real-time knowledge and assessment to critical decision makers within the Pentagon and to the Fleet, and I know that we've been able to adequately advise SECNAV, CNO, Commandant, and many others who are there to make very important decisions for our Navy.

Actions by Navy Medicine during the early stages of the pandemic directly impacted our ability to better understand how the virus behaves, how to contain the virus and keep it from spreading and effectively support mission accomplishment. Early on in the fight, and SG alluded to some of this earlier in his comments, Navy Medicine deployed a biological defense research mobile team to the Theodore Roosevelt providing the first COVID-19 detection onboard a U.S. Navy ship. And we also deployed preventive medicine units and rapid response teams aboard ships to provide force health protection threat assessments, mitigation measures support and testing of the crews. And in order to support the Fleet's capacity to prevent, diagnose and treat COVID-19 while under way, Navy Medicine answered requests for support from additional preventative medicine experts, advanced SARS-COV2 testing platforms along with the personnel and supplies to run them and additional infectious disease and critical care specialists.

We worked very closely with NAVSEA early on to rapidly identify, evaluate and embark Ultralow freezers and buying devices aboard ships to support the storage and potential use of COVID-19 convalescent plasma (CCP) for the treatment of sailors and Marines with severe COVID-19 disease while forward deployed. Thankfully, we never had to utilize CCP within the Fleet.

Through Navy and Marine Corps Public Health Center, early on we utilized advanced population health analytic resources to develop and apply dynamic probability, COVID-19 modeling capabilities, and these provided estimates of COVID-19 cases over time to help units and military treatment facilities plan for adequate supply, staffing and bed capacities.

Once again, Navy Marine Corps Public Health Center provided infection risk estimates associated with different restriction of movement timeframes, so they looked at seven, 10, 14 and 21 days for ROM and testing strategies to inform operational risk management decisions in establishing pre-deployment near, what I would

call, infection-free bubbles around ship-borne crews. And more recently, modeling by Navy and Marine Corps Public Health Center demonstrated crew immunization of 85% or more will ensure sufficient herd immunity for crews of all sizes, such that any cases escaping detection will result in minimal ongoing propagation until the 19 burnout. This model was validated during an outbreak aboard a CVN at sea following a single dose of vaccine administered to 72% of embarked personnel at the time of deployment.

Data from active duty personnel is validating vaccine efficacy in our force. We've had only 105 COVID cases in immunized Navy personnel since the introduction of vaccine-that's .87% of all infections. And there have been no cases resulting in hospitalization or death for fully immunized active duty Navy personnel.

In the last four months, only 62 out of more than 11,000 COVID cases and active duty Navy personnel have required hospitalization. That's .52%. And of those 62 cases, 60 were unvaccinated and two were partially immunized less than 14 days after the first vaccine.

A Navy research study in Marine recruits showed that young adults who have recovered from COVID have 1/5 the subsequent infection as previously uninfected young adults. But what may be more important is that it appears that natural infection does not offer as much protection as immunization.

In the face of significant obstacles, Navy Medicine continued to persevere, and no matter the challenge, all of you out there have done an incredible job of rising to the challenges and exceeding all expectations.

To date, Navy Medicine had deployed over 4,500 active component and over 1,400 Reserve component sailors in support of the nation's pandemic response. Over and above operational support, the SO18 activities have dedicated more than 700 full-time equivalencies across the enterprise in order to manage the pandemic and meet the mission. And it has been an all hands on deck effort as Navy Medicine had utilized personnel from every single corps for swabbing and vaccinating, while setting up operations in parking lots, gymnasiums, tents, theaters, and other spaces of opportunity to make testing and vaccinations easily accessible.

The COVID-19 global pandemic had presented the Department of Navy and our Nation with unprecedented challenges and has stressed the entire force. With grit, resiliency, initiative and rampant application of lessons learned, we survived first contact with this insidious enemy. But we must never forget those we have lost in this battle while continuing to generate, deploy and sustain combat ready forces.

The success of the past year and a half would not have been possible without the entire One Navy Medicine team linking arms to carry out our mission. Special thanks to all of our commanding officers, executive officers, command master chiefs, our civilians, Reservists, Fleet, Fleet Marine Force surgeons, regional headquarters staff, Navy and Marine Corps Public Health Center, our forward deployed preventive medicine units, legal medicine, logistics command, Naval Medicine Research Center, Naval Health Research Center, our FIOs, our BUMED deputy chiefs, action officers, commanders action group, our testing and vaccination teams, scientific panel and countless others who have contributed to the fight. All of you continue to provide the expert guidance needed to ensure the best possible experience for each and every one of our patients every day while having a constant eye on delivering our vision for the future. Collaboration, integrity, wisdom, compassion and excellence are just a few of the many attributes that all of you bring to the table every day, and I cannot be more proud and inspired by the One Navy Medicine Team.

SG, I don't know if you know this number, but as of today One Navy Medicine team has delivered 930,000 vaccines across the Department of Defense, so we'll be reaching that one million mark here in the next few days. It's quite an achievement. We're not done yet, but we're making significant strides and I know that everyone will continue to keep pushing forward so that we can stay in the fight and keep our Navy and Marine Corps team ready to go. ●

Deputy Chief for Business Operations Remarks

As I pointed out to the Flag Mess earlier this year, I have an e-mail hanging on my wall dated January 17, 2020 that says, "Mr. Oliveria, just returned from a meeting at OSD about a virus that's emerging from Wuhan, China. However, person to person contact does not spread the virus and I'll get you more on it as this develops." Well, that was the first salvo in the war that DSG and the SG and others have described to you today. So I want to talk a little bit during my time here about the things we did right, some things we certainly learned as we went along the way. There are those that say we were trying to build the aircraft post flying, and as an old aviator, that is just too ugly a picture for me, so I would prefer to say that we were in the aircraft, we had a flight plan filed, we were running down the runway and we realized that it was going to take military power to get us airborne, but we had a good crew-the people behind us; we had a solid platform--Navy Medicine--to work with; and we were going to fly our mission and a performance to lead to the power that we were going to project over the next year and a half.

On very short notice we stood up the watch and OBT [Operations Business Team]. I remember Dr. Malanoski calling me saying, "Ollie, are you standing up at OBT."

And I said, "O.B.T. Okay yes, I think we'll do that." And then I found out that my staff, when I needed to stand up the OBT, half of them were in Texas and the other half were in Portsmouth taking care of a bad health issue. So we stood it up as soon as we could. We stood up a watch team very quickly, and we also established a website and an avenue by having a watch of anybody 24/7 could submit questions and concerns about how we were handling the pandemic. Our PHEOs went into full-speed, were ready to help the surgeon general and deputy surgeon general, leaders of the Department of the Navy and the Department of Defense establish policies and help us get through the next year and a half. We found out that we probably didn't have as deep advantage as we thought when it came to standing the watch, so we had to work on that and develop some junior officers and others, their skills as watch standing and handling information flow during that watch, and how to make sure the leadership stayed aboard.

The next step was the PPE, personal protection equipment. We found out that our decision that had been made years before to centralize our PPE and store it here in Maryland was a great decision. We, unlike the other two services who suffered through having outdated equipment in the MTFs that are spread throughout the world, we found that we knew exactly where our stuff was and when it was going to go out of date if it was and how to replace it. It turned out to be great. We were able to distribute ours.

Mr. David "Ollie" Oliveria

We also found out that by centrally locating it and trying to get it overseas during a pandemic was a little bit of a challenge, and maybe in the future we need to look at perhaps place the stuff overseas, but at the same time, that's where the Army and the Air Force got in trouble, because the Air Force, the stuff they had overseas at MTFs was outdated and they ended up having to replace it, and actually we helped them in one case.

The next step was the testing equipment. We found out that we had a great logistics system that had the elasticity to expand and order the stuff. We made sure that we could order the testing equipment as it became available, but we found out that the national shortage of testing equipment impacted our ability to respond to those kind of-such as the TR that was mentioned earlier. But certain groups, our logistics command, particularly LOGCOM was capable, ready, able to order everything that we needed and had the right mechanisms in place to do it.

Then, of course, after we got through the testing, the vaccine came next, and we went into gear of how to manage the vaccine, initially working very closely with DHA as they set up their OBT. And then of course working with OPNAV and the Office of the Marine Corps to make sure that we distributed the vaccine in a manner that would meet the operational mission and reserve readiness. Quite an accomplishment when you look back at it. We're still flying the aircraft; we still got gas in the tank. We're not sure when we'll get to land, but we still got a great crew behind us and a great platform to fly on-Navy Medicine.

So, some things that we learned as we deployed the two EMFs and then the personnel from EMFs, short of the equipment, we found the need to supply certain equipment. That was not always planned as the SG said. We were learning towards battlefield surgery, and now a pandemic required some adjusting to our requirements and our EMFs, so we had to adjust on the fly. But again, NEMSCOM and LOGCOM came through for us and they did what they needed to do to get the right stuff in place.

As was mentioned, under the SG's guidance, we stood up the newsletter, which became invaluable in cutting down the number of requests for information that we had for leadership. It allowed us to get ahead of that information flow and allowed also, to us and particularly our PHEOs, to display their expertise in leading the policy development.

I also want to note that throughout this we developed a process for contact tracing and a web based training platform that the whole Fleet could use to help develop local contact tracing resources as it initially really drained our PHEOs and our medical staff as they took up the role of contact tracing. But by developing that training as quickly as we did-shout out to support communities that helped us do that-we were able to provide some really-I haven't been with Navy Medicine, but a mere 15 years now, but in that time we've never launched both T-AHs. I was amazed that we pulled it off, but again, great people, good platform, performance-all was there and put together and we were able to project power, as you saw in the great videos we saw. Just amazing to me, as someone that did ship work for a number of years, and getting underway for us was always-you know, you had your fast crews and then you got underway the first day and everything's kind of calm the first and second day until you brought the air wing aboard and everything started to pick up. We went full speed right out of the gate with our crews and what they were doing, and it was very impressive.

So, of course, I want to bring up also that throughout this shortages and the problems that we experienced we're not Navy Medicine's making. We were the solutions to many of those problems-managing shortages, equipment shortages-whatever it was, we were depending on a national supply, and I think our nation learned a lot as we put the demand signal in for what we needed to help keep our force ready, and the SG and DSG both articulated that in their statements in front of BSO-18 and also in front of Congress of what we were able to do.

The other lesson we learned, and I want to emphasize the value of public health officers, public operations officers. We don't have enough PHEO, and if you don't know, to be a PHEO you also have to be an MD, and so that makes it a very valuable commodity when someone is a PHEO. Thanks to Dr. Malanoski's efforts, we were able to augment the regular PHEO staffs and we had extra people throughout the process, but now that we're tapered back down to normal OPS, we're not going to be able to provide that one on one direct support to the level that we have throughout, so we will need to look at how we are going to manage in the future our PHEO population and our PHEO support.

The other issue I want to bring up and make note, and it's not really in my swim lane, but it is one that certainly we recognize throughout as our lab personnel. As we geared up the testing equipment and we geared up our ability to test, we found that lab personnel was a shortage that really limited our ability to respond. Even as the equipment started to flow, and there was a delay in recording the testing equipment, adding the right people to be able to conduct the test became a limiting factor and remained so throughout.

So again, I feel very fortunate to be part of this team. We are really pleased with the way the deputy chiefs here at BUMED came together to work this. ●

SGLS: EXECUTIVE DIRECTOR'S MHS TRANSITION UPDATE

Before we get started I wanted to begin by talking about divorce, and it's a subject that I think we're all familiar with; some of us have been through it, remember it somewhat fondly; others have family members or friends who have been through it. And I think when we think about divorce they all start the same, and I'll call it phase one.

In phase one, both people have a lot of anger; they have a lot of regret, they have a sense of loss. There's almost no trust. And much of the time is spent rehashing things that have happened that have caused the divorce, or trying to assign blame on who did what as events occur. And for some, that's where you stay. You just stay in phase one. But most will move to phase two.

And in phase two, each party is looking at moving on with their life, and they're trying to figure out the fastest way to end their relationship, and so it is all about dollars and cents and resources, who owns what, who gets what, who doesn't get what. During this period, it's a bit more professional, but it's not necessarily cordial. If you're lucky, you have an arbitrator, if not you have two lawyers who are your seconds, and you proceed along until you've got joint assets divided, and if you're lucky and you're in the Navy, you move to your next duty station and the other individual stays behind. If you're not, you will then often move into phase three.

In phase three--and I think what's where most people are because most people have kids, and there is a realization at some point that you can't end the relationship. You will have a relationship with the other individual--it will be different, but you have to identify how you are going to manage time and roles and responsibilities related to those things that you keep in common, and most commonly it's kids, it's friends, it's occasionally business relationships, and it takes time to get through that, but when people have the light bulb go on, and luckily it did for me, you end up in a pretty good place, but it takes time. And so hopefully people are quick enough to be able to take what this is and relate it to our present situation.

Dr. Michael Malanoski

So, although we are not married to DHA, we did have a much different relationship when this started. There was a decision that that relationship would change, and I think if you step back we have gone through the first two stages. We made decisions in those first two stages that were somewhat based on emotion and some were based on what our desired endpoint was. And at one point in time, the desired endpoint was to separate ourselves as much as possible from DHA, identify what they needed to do for us and we would identify what we needed to do for them, but keep it strictly business and the two parts would go just swell. I think as we have had time and the ability to step back a little bit, we realize that in some cases some of our assumptions related to what end state would look like were not quite in line with what we needed to ensure that the children--and don't take this condescendingly, but you out there are the children--that we are doing what we need to do to support you because that's what parents are supposed to do. It is not supposed to be about the parent; although, often in divorce for a period of time it is. But sooner or later, hopefully good parents wake up and realize it is not about them; it is about the children and how they can

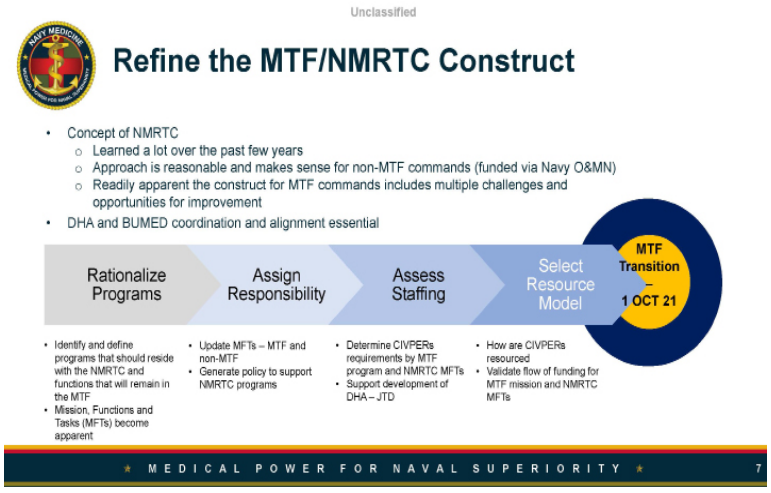
make them successful. And so what this brief is going to do is walk through where we are right now. I do think you'll see that what we're trying to do is look at it from a different perspective. We're looking at it from the perspective of what does the field need to be successful, not what we, headquarters, believe we need to be successful, and I am optimistic. I do believe DHA is also along this path, and although we're not always at the same place, I think we are all moving in that direction here in D.C. and hopefully we'll make you all's life easier out there.

I want to spend some time on here, these are the six equities and these were established right at the start. I won't go over them one by one, but most of them relate to our uniformed personnel and our mission as it relates to operational support.

When we step back and look at the MTF, the MTF presently is a military command that as part of its mission does benefit delivery. And I'll say it again, the MTF is a military command that as part of its mission does benefit delivery. We often don't look at how much of the mission of the MTF is not related to benefit delivery, and so you have the platform, you have sailorization, you have all of the other elements that relate to our officers and how they get ready to go out to the Fleet and the Fleet Marine Corps. You have the support of the installation. You also have a regular flow and a routine flow back and forth between the MTFs and operational units, and it's not related to the platforms in most cases, it's the onsies and twosies that occur on a day to day basis. All of that is not benefit delivery, it relates to the military command element of the MTF. Those six equities are how do we ensure that we can continue to do that military command element of the MTF as we move forward?

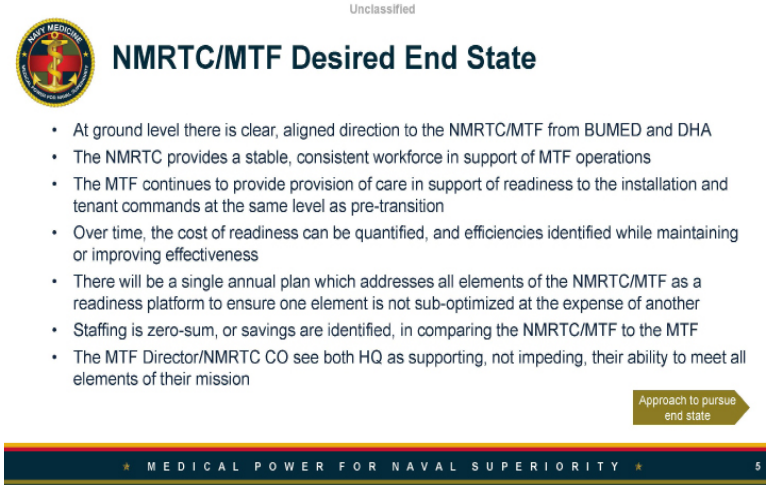
I want to emphasize when you look at those six equities of transition, that's an end state. There are a lot of different ways you can get to that end point. When we started, and where we are right now, we decided to use the NMRTC construct to meet those six equities, and without going into great detail on the NMRTC construct, it's fairly simple. It says you have the uniformed personnel and those civilian personnel that are focused on non-provision of care, or non-benefit delivery, and they form a command. Interestingly enough, it's actually not a new command because we retained the units from the MTF, it's the same command but now it has a tailored, more specific mission. And that NMRTC does the military command elements of the mission, and in addition to that, it provides personnel who work in the MTF. Those who have been associated with the Army, this is close-not exactly the same-but it is the idea of the troop command within an MTF. It is not that the NMRTC and the MTF are competing--it was never designed to be that way. They're supposed to be mutually supporting of each other.

There are some challenges related to that construct, which we are working through now, not the least of which is how money flows, and the fact that when we get right down to it, it is difficult to pull out and separate the military command elements from the provision of care elements. We have multiple MTFs now that have moved over to DHA--Jacksonville, PAX, Annapolis, Quantico--all of them have a construct that is



described in the MFTs that all of you have seen who are at MTFs, but when you talk to those COs on the ground, they still function pretty much the way they did before, they just have two chains they then have to report to, so they have duplication of reporting requirements; there are often times when direction comes down from the two headquarters and it is on the same issue but different direction and they have to try and sort that out. This is the part that we have not quite gotten right as a headquarters, and that's both DHA and BUMED. And as a result, we will have to tweak that NMRTC construct.

The other piece to it is, as I mentioned, because the resources-and the people are the resources, we all know the constructor of an MTF and it's about people because you can't separate, and in some cases a person doing NMRTC business in the morning and MTF business in the afternoon, you're going to run into problems related to audit, etc., because the Navy dollars are all M&N and the DHP dollars are DHP dollars. So we have to work through that, and that's what we are doing now with DHA.



So, it's always good to start with a desired end state because that then allows you to do a gap analysis and determine where you need to get to. And I don't usually read slides, but I do want to walk through these one at a time because I think they're important. And again, this is a starting point; it's not necessarily where we will end up related to desired end state, but I do think it's important that when we start modifying NMRTC and talking to DHA, that we all have a common end point, so when we have two COA we can print it as COA as to how well they support that desired end state.

So the first one is a ground level that's for the MTF NMRTC. There is clear line direction to the NMRTC from BUMED and DHA. That means that we won't have both commands giving direction on the same issue. We won't have both headquarters putting out policy where one policy impacts the other, but it is not being coordinated, and we won't have a situation where the MTF, when it does for those things, has to go up to both headquarters separately, and then hope that in their lifetime they get an answer back. What we'd like to establish is a single pipeline down to the MTF NMRTC and a single pipeline up. There is some challenges related to that, but that is the end state we desire.

The second bullet is fairly simple and I think we all agree to it, but it needs to be stated so that DHA realizes that we, Navy, are a willing partner and understand our role-rightfully so DHA is extremely nervous about a lack of consistency in the uniformed force. We sit in the middle-about 40% of our MTF work force is uniformed, where the Air Force is about 80% and the Army is about 47%-it's a good chunk. If they don't have consistency in that workforce then it's almost impossible for them to do planning. And so when you talk to DHA, they will continually come back to this point. Now, we all understand that consistency in work force in the line of business we're in is a relative term. That's why the MTFs are inherently inefficient. The purpose of them is not just to do provision of care; they are a readiness platform, but I do think we need to make sure we do work through this, we are consistent in trying to get that stable workforce and that signal related to it as consistent as possible, and to be as agile as possible as things change so that DHA has real time updates as things go along.

The third bullet, and that relates to the issue of what DHA does and what we do-looking at the MTF not as two separate entities because there are going to be some pieces that the MTF will do and some that the NMRTC will do, and that's the counter to the second bullet, which is that the MTF continues to provide provision of care in support of readiness to the installation and tenant commands at the same level as

pre-transition. So, we've all been on bases where that MTF, you look at its numbers and it doesn't look good and it's because they have a high tempo in supporting the installation and the tenant commands on that installation. This is particularly true at Marine Corps installations where they have to do a lot of support, field exercises, etc. We want to be able to hold DHA accountable that related to provision of care they are going to put the same emphasis on readiness as the first priority that we have now.

The fourth bullet, I think, is an important one. We have hidden behind readiness as a reason why we are inefficient for a long, long time. We have never really quantified the cost of readiness, and as a result, we've never really tried to identify inefficiencies in the cost of readiness while maintaining effectiveness. I do think there is significant opportunity here and this is something we have to work towards, because at the end of the day, right now, all of the funds within the MTF will be DHP funds, and what we spend on readiness they can't spend on provision of care. They are expecting, and they are expected by Congress and the rest of the Department, to identify efficiencies within their scope, and if we can't help them related to making our readiness piece more efficient, which now allows them to have more time for their provision of care piece, then we would not be good and transparent partners.

The fifth is there is a single end player that addresses elements of the NMRTC/MTF as a readiness platform to ensure one element is not optimized at the expense of another. We have, from the very beginning of this, talked about DHA as a provision of care and we have readiness. That's not exactly correct because a significant element of readiness is provision of care. And so when we talk about readiness, we have to be able to identify and quantify what DHA needs to do to support readiness. That's not to say that DHA owns readiness. We set the requirements and we have a big piece of execution too. But if we are going to be good parents, we can't say, "We are going to look really good, and they are going to look who cares?" We have to look at the entire mission of the MTF/NMRTC as a whole and ensure that we're not sub optimizing one area to make another area look really good. An example, and it's a simple example, we have all of our readiness platforms at 100% across the border, and it takes us asking DHA for our people to spend 75% of their time on the platform work and 25% of the time in provision of care. We look really good. We are really happy. The DHA is basically not able to sustain itself. That won't work. So we have to be able to balance. It's not an all or none phenomenon and that's where we have to get to.

The next to last bullet is zero sum game, same as identified in creating the NMRTC and the MTF. I think this is important when we can't have growth, and understand that there are going to be inefficiencies until we get started. We're asking people to work harder so we can say there is no growth, but I do think over time there should be efficiencies identified on both sides, and because the MTF/NMRTC constructor is people. When you identify efficiencies then you should require less people over time. We have to work towards that because without that as a north star, we will cost more and given the way things are inside the beltway that's not good.

And then the final--and this is where I started--the MTF director, NMRTC CO sees both headquarters as supporting and not impeding their ability to meet all elements of the mission. If we're making life harder for those out there, both the regions and the MTFs and all our other commands, we're making it harder for them to do mission, then we are not a successful headquarters. Our job is to give direction and then to provide support.

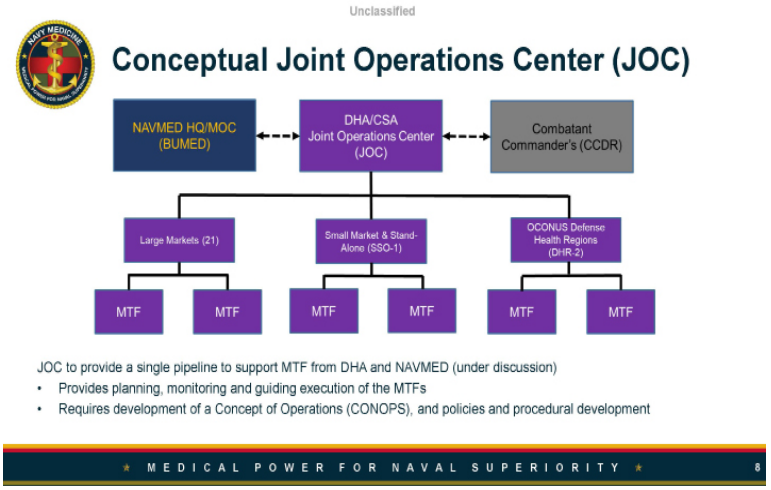
So, how we going to do this? And it's not really that hard, at least the concepts, or the steps. I'm working through them and we'll take a little bit of time, but I do think it's fairly straight forward. We're going to start-and we've already done a first cut on this at looking at what are the programs that BUMED presently has related to the MTFs? And which of those programs will we retain? Understanding that a headquarters primarily does three things-it does policy, it does oversight, and it does resource allocation. So, if we identify a program that we will retain that says we will do the policy on that program. If there is something being done in the MTF and it's not attached to a program, then it probably shouldn't be being done

in the MTF. And so you ought to be able to trace back everything that the MTF does through our program in some way, shape, or form. So I think people can see how this goes. If we've identified the programs that we have, and DHA has the programs that they're executing and we look at the two lists there should be no overlap because you can't have two entities doing policy on the same program. That should clarify lanes going down. Once we have who's doing what policy, then the next step is who will execute the policy. If you want to look at our present approach, BUMED sets the policy; the regions execute the policy. Now, they may put out policy of their own as execution, but the important thing is they're doing it under the direction and following the policy of the headquarters. So there may be situations where we set the policy, but DHA actually executes the policy. The reason this becomes important is because the money and the people that are tied to the execution.

So, let's take three examples. A policy that you will most likely own in the end and how this can end up different. We will have the policy on DHA because that's a service responsibility. We'll have the policy on a DRP program. We'll have the policy on DEPMED. Now, for the PHA, the vast majority of the PHA work is what? It's provision of care. So it may be it makes sense that the DHA simply executes our policy and we track them as to how well they are executing them.

We look at BRP, well, there's provision of care there, but that's a bit more complicated. For those who have experience in it, there's a tight connection between BUMED and new power related to it. We provide the staffing; we provide the reports on a regular basis. We are held accountable for that. So that one is going to probably take some negotiation. And then you go to the third, we set policy on DETMED, those are military units; they are embedded operational units. The SG needs C2 of those units. And so we would not expect DHA to execute the DEPMEDS unit, that just doesn't make any sense. So I think, hopefully, people see how this approach would end up clarifying lanes between DHA and BUMED as to who has policy and who has execution.

And the last two steps are fairly easy. Once you identify execution, you have to identify the staffing required for that execution, and then after you have the staffing how it will be a resource. And so that's what we're going to walk through, hopefully over the next few months to come to what is that interface between DHA and BUMED, and then how it relates to the MTF and NMRTC.



This is just another way to say that that looks cooler because I'm all about coolness. So, now we have who owns what. How do we tell the MTF who does what? And I do think this is the second major line of effort, which has started-it's going to take a little bit of work, but the idea is that there will be a joint operation center and it would have elements--initially it will be, right now DHA And Navy, the other two services didn't mind us going first--I guess they have other things to do-which is good for us because we get to work with DHA to set up how this will work. But the intent and the end stay related to this is there will be a single operations center, and for us you can think of it as the secretariat where direction, guidance, policy-whatever-flows down from BUMED into this joint operations center. They look at it compared to what's coming out of DHA. They de-conflict. They ensure alignment and then from there it goes down to the MTF/NMRTC.

DHA has to stand up their own operation center before they can there; they have started to do that. We are working with them on that. I would hope that we would have something that would be first stages of this sometime in July/August, understanding that I'm often optimistic related to when things will be done. But I do think it will be a key point because when you

talk to those that have already transferred, I think this is the major heartburn that they have at the present arrangement, that they are the ones that have to try and figure out what is going on rather than just saying there's conflict, please address and get back to us. And that's what we're aiming and trying to do.

The third area that defines the interface is the performance of the MTF/NMRTC, and right now as it stands, DHA has their QPP; we have our RPP. There are some elements that are supporting; there are some elements that are duplicity there. And so what we do is we identify readiness command signal, which is how much more force that we need to retain to do our work, and if you do that one minus total, then you get how much workforce they have to do their work. But we also ask for process improvement projects that align with SG direction. DHA does the same thing on their side. It's a little bit unclear when a project straddles that fence, who tracks it, etc. What we're working towards, and hopefully we'll be able to do for next year-if not we'll get closer to it-is to have a single guidance come out from the headquarters, a joint instruction to the MTF/NMRTCs that then will require a single submission from the NMRTC and MTF back up the chain, which will then be presented to both headquarters, and they will arbitrate and negotiate as to what should and shouldn't be done. Hopefully if not this year, then the year following match that against resources.

And so that's all good. But, without some mechanism to assess performance, all is for naught because I think we all understand that the key to driving performance is positive thinking and regular performance reviews. I would say that this is the area that both us and them have been a little bit lax on. I think you in the field, while you complain about us sending a lot of stuff, we have not been having regular performance reviews, which can sometimes be painful, and which require people to stay on track. As a result, some of the performance across the MHS has suffered, and so people may not be excited about this, but I do think the effort will be to ensure that both sides are seeing what the other is doing so that we don't have a situation where one side is hammering an MTF that has significant readiness requirements as an example, and they are getting asked to do things they can't do on a provision of care side, or the same thing on the other side where there may be some plans that were supposed to happen that didn't happen, and there is a readiness asset, if you want to think in resourcing term, and yet we don't tell DHA, "Look, you can increase your production," whatever it may be because that may occur. So again, these two pieces together then allows us to ensure that the MTF is not fraught with some optimizing one mission against the other.

Don't want to forget public health and research and development. Public Health is going to be a challenge. I think COVID has highlighted and underlined and put a star next to it the importance of public health in the operational setting and in everything we do. We could not have responded to COVID without Navy Marine Corps Public Health Center, as well as our headquarters people, but they were critical to a lot of the analysis and a lot of the work we did. In addition to that, we have operational units like the MTFs embedded within that structure, and so we are going to have to work with DHA as to what the model will be going forward to ensure that the Surgeon General can meet his needs-the needs of both the Marine Corps and the Navy related to public health, and at the same time meeting statute, and there will be more to follow on that. And so that is, in a nutshell, transition. ●

What's Behind Vaccine Hesitancy Among Members of US Military?

On May 11th, Rear Admiral Gillingham appeared on the NBC TODAY Show discussing the issue of COVID-19 vaccine hesitancy in the military. The following is a transcript of this story.

HAILLIE JACKSON (HJ): To most people, it's simply a shot; but to the military, it's like "biological body armor," at least that's how the Navy Surgeon General describes it.
BRUCE GILLINGHAM (BG): This is no different than putting on a helmet and a flak jacket in a combat zone.

HJ: Admiral Bruce Gillingham says more than 40% of the Department of the Navy has been vaccinated already, but the latest numbers available show more than 1/3 of all Marines offered the vaccine have declined. That's a higher vaccine hesitancy rate than estimates for the rest of the country.

HJ: Is that a figure you're concerned about?
BG: Some individuals have decided that they want to wait and see. And so for those fence-sitters, we are now beginning to see those individuals come and get the vaccine. So I think we're seeing a positive trend.

HJ: The Navy says some of those who declined may have gotten the vaccine on their own, or might be waiting until the shot becomes mandatory. For now, it's not with the vaccine still under emergency use authorization.

LLOYD AUSTIN (LA): We still believe that the right focus is to provide the best information available, and this will help our troops to make informed decisions.

HJ: Craig [Melvin], asking President Biden about it in his exclusive interview last month.

CRAIG MELVIN (CM): Will you order service members to get the COVID vaccine?
JOE BIDEN (JB): I don't know. I'm going to leave that to the military.

CM: Why not?
JB: Well, I'm not saying I won't. I think we're going to see more and more people getting it.

HJ: According to the latest vaccine numbers released by the Pentagon, about 30% of the military has been vaccinated; more than 600,000 troops across all branches, and a quarter million more have had at least the first shot. Jake Wood, deployed to Iraq and Afghanistan during his time in the Marines, now with Team Rubicon, he's mobilizing veterans to volunteer at vaccination sites across the country.

JAKE WOOD (JW): Whether you like to admit it or not, the potential for COVID-19 to knock you out of the fight, it's there. We owe it to Americans to ensure that we're as ready and capable to defend our interests.

HJ: Admiral Gillingham says it's critical to make sure the vaccine is available, along with good information about it.

NBC News Correspondent Haillie Jackson interviewing RADM Gillingham at the Bureau of Surgery, May 2021.
Photo by Mr. Joe DellaVedova

HJ: Do you see a point where this vaccine, in your medical opinion, should be mandatory?
BG: In this case, I think we've seen that the vaccine is very safe, and so I think there's a strong argument to be made for that, and that, ultimately, is the Secretary of Defense's decision.

HJ: Do you believe that things are trending in the right direction as it relates to the Navy?
BG: Hallie, I'm cautiously optimistic that we're really beginning to turn the corner, but I would emphasize, we cannot take our foot off the gas.

SAVANNAH GUTHRIE (SG): And Hallie, what is the precedent for mandating a vaccine within the military?
HJ: There is a precedent for that, Savannah. There are other vaccines that are required for people who are in the military, but the deal with the COVID vaccine, remember, it only has that emergency authorization now from the FDA, and not full approval, so that is something that could change, potentially soon. We know that Pfizer, for example, has already filed for that full approval. So if and when that happens, I think we can expect to see, based on the conversations that I've had, more pressure will be put on the military to go ahead and make this shot required for service members.

KNOW YOUR PLATFORMS: VACCINATION SUPPORT TEAMS

In mid-February 2021, Navy medical personnel began deploying across the United States and U.S. Territories as part of Vaccination Support Teams in support of the Presidential-directed COVID-19 vaccination mission. The size of these teams have varied based on the need at site. Type 1 teams can comprise up to 222 personnel, Type 2 teams can include up 139 personnel and a Type 4 team includes 25 individuals.

The Vaccination Support Teams are overseen by U.S. Army North, U.S, Northern Command's Joint Force Land Component Command, and operate in support of the Federal Emergency Management Agency (FEMA) and the Department of Health and Human Services. As of May 11th, 2021, Navy medical personnel have been deployed to 12 states and a U.S. territory in support of this mission and helped administer over 930,000 vaccines.

FLORIDA:

• As part of a Type 2 Team, Navy medical personnel began supporting a Community Vaccination Center (CVC) located at the Gateway Mall in Jacksonville on February 26th.

LOUISIANA:

• As part of a 140-person, Marine Corps-led Type 2 Team Navy medical personnel began supporting the federal pilot Type 2 CVC at the Bon Carré Business Center in Baton Rouge on April 9th.

MASSACHUSSETTS:

• A Navy-led 220-person, Type 1 Team began supporting the federal pilot Type 1 CVC at the Hynes Convention Center in Boston on March 26th.

MISSOURI:

• A Navy-led 140-person, Type 2 Team began supporting the federal pilot Type 2 CVC at The Dome at America's Center in St. Louis on April 9th.

NEW JERSEY:

• As part of a Type 4 Team, Navy medical and Army personnel arrived in New Jersey on February 11th to support CVC sites at the First Baptist Church of Lincoln Gardens in Somerset and in Paterson at the Calvary Baptist Church and the Cathedral of St. John the Baptist.

• As part of a Type 4 Team, Navy medical and Army personnel arrived in New Jersey on February 19th to support CVC sites at Thomas G. Dunn Sports Center in Elizabeth and at the Maureen Collier Senior Center in Jersey City.

• As part of a Type 4 Team, Navy medical and Army personnel arrived in New Jersey on February 19th to support CVC sites at the Iglesia Pentecostal Church and Trenton Central High School in Trenton. Members of this team also began supporting a CVC located at the BB&T Pavilion in Camden on March 8th.

• As part of a Type 4 Team, Navy medical and Army personnel arrived in New Jersey on March 5th to support CVC sites at the St. Matthew AME Church in City of Orange (one pharmacist and six hospital corpsmen) and at separate sites in Newark (two pharmacists and two hospital corpsmen).

NEW YORK:

• As part of a Type 2 Team, Navy medical personnel (91) arrived in New York on February 20th to support a CVC at York College in Jamaica, Queens, N.Y.

OKLAHOMA:

• A Navy-led 140-person, tailored Type 1 Team, modified at the request of the state to meet Type 2 CVC requirements, began supporting the federal pilot CVC at the Tulsa Community College Northeast Campus in Tulsa on April 16th.

OREGON:

• Navy medical personnel with a Marine Corps-led 100-person, tailored Type 1 Team, modified at the request of the state to meet tailored Type 2 CVC requirements, began supporting the federal pilot CVC at the Jackson County Expo in Central Point on April 16th.

PENNSYLVANIA:

• As part of Marine Corps-led Type 1 Team, Navy medical personnel arrived in Philadelphia on February 26th to support a CVC located at the Pennsylvania Convention Center.

TENNESSEE:

• Navy medical personnel with a Marine Corps-led140-person, Type 2 Team began supporting the federal pilot Type 2 CVC at the Pipkin Building at the Liberty Bowl Memorial Stadium in Memphis on April 2nd.

TEXAS:

• As part of Marine Corps Type 1 Team, Navy medical personnel arrived in Arlington on February 19th to support CVCs at Globe Life Field and AT&T Stadium.

VIRGINIA:

• A Navy-led, 140-person, Type 2 Team from the U.S. Navy began supporting the federal pilot Type 2 CVC at the former Macy's in Military Circle Mall in Norfolk on March 26th.

VIRGIN ISLANDS:

•As part of a Type 4 Team, Navy medical personnel (one pharmacist) and Army personnel arrived in the Virgin Islands on February 26th to support a CVC located at the University of the Virgin Islands campus on St. Thomas.